Information Exchange Workgroup
Draft Transcript
February 2, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the HIT Policy Committee's information exchange workgroup. This meeting is being held in public, and the public will have an opportunity to make comments at the close of the meeting. Workgroup members, please remember to identify yourselves when speaking, and a transcript will be made available of the meeting within the next five to seven days on the ONC Web site. With that, let me just do a roll call. Jason Brown, standing in for Judy Faulkner?

Jason Brown – Epic – e-Prescribing Lead
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
And Thanos, is he on yet, Tsiolis? Connie Delaney? Gayle Harrell?

Gayle Harrell – Florida – Former State Legislator
I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Frank Nemic? Michael Klag?

Mike Klag – Johns Hopkins Bloomberg School of Public Health – Dean
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw?

Deven McGraw - Center for Democracy & Technology – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Charles Kennedy? Paul Egerman?

Paul Egerman – eScription – CEO
Yes, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marty LaVenture?

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics
Yes, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Dave Goetz? Micky Tripathi?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jonah Frohlich?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Hello. I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Steven Stack?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak? Paul Tang?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jessica Kahn? Did I leave anybody off? All right. With that, I'll turn it over to Deven and Micky.

Deven McGraw - Center for Democracy & Technology – Director
Okay. We have the public on the call, right?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, that' correct.

Deven McGraw - Center for Democracy & Technology – Director
Okay. Great. By the way, Micky, I have control of the slides.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Okay.

Deven McGraw - Center for Democracy & Technology – Director
Here's our agenda today. The policy committee meeting on the 17th of February is going to be focused. I don't know if it's primarily on the notice of proposed rulemaking and the IFR, but certainly that's kind of our last – that meeting is our last chance to get the policy committee to potentially endorse any comments that we would want to make to those rulemakings because the public comment period essentially closes before our policy committee meeting in March.

What we thought made the most sense for this call is to focus it specifically on the meaningful use notice of proposed rulemaking in the area of labs and e-prescribing, now that we've had our hearing, to see if there are any specific comments that we want to make and put before the policy committee for endorsement. Then I think it makes sense for those issues for which there's a little bit more time for

consideration of appropriate recommendations, particularly in the e-prescribing area, we would schedule subsequent calls to have discussions on those. Micky, am I characterizing that right?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. Absolutely.

Deven McGraw - Center for Democracy & Technology – Director
Does anybody have any questions about that?

Paul Egerman – eScription – CEO
Are we also going to be talking about the IFR?

Deven McGraw - Center for Democracy & Technology – Director
Yes. So here's the part that maybe staff can illuminate. The policy committee is focusing primarily on the meaningful use policies, which are in the NPRM. I know that some of the standards folks have been told that they should really – that comments about the rightness or appropriateness of specific standards is really in the purview of the standards committee, and that's what they're supposed to focus on. While I wouldn't say that comments on the IFR are out of scope necessarily, I think they'd have to be sort of towards maybe the mix of policy and standards piece of that versus pure standards, right, wrong, although I guess one could also argue that we can say whatever we want. And whether ONC or the policy committee takes the recommendation or not would be up to them. But that's my understanding of the landscape. Does anybody from ONC want to jump in?

Jonathan Ishee - Department of HHS - Policy Analyst
This is Jonathan Ishee. I think that's correct, Deven.

Paul Egerman – eScription – CEO
This is Paul Egerman. The IFR has a certification criteria. So having read through the slides, I have a feeling that some of the things we may want to accomplish might be accomplished through comments about the certification criteria in the IFR.

Deven McGraw - Center for Democracy & Technology – Director
Right, right, which is fair, so I think, to the extent that it's a comment that's not about, well, that standard is not specific enough or not appropriate. That may be a little trickier, but why don't we –we've got at least three hours scheduled today. And, to the extent that I think people in the workgroup have concerns that they want to raise, I think we should go ahead and talk about them, and then think about what's the best way to communicate that. Does that make sense?

Paul Egerman – eScription – CEO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Okay. All right, so let's go ahead and dig in. Now these slides are not draft policy committee slides, per se, although certainly we would probably use them to create policy committee slides. I crafted them largely to help us on the workgroup walk through what's in the meaningful use rule that pertains to meaningful use in the IFR that pertain to lab and e-prescribing, which is what we've been focusing on, and to help us come to conclusions versus this necessarily being what I'm proposing what we put before the policy committee. That's just a framing matter.

Starting with the exchange of lab data, this is just a reiteration of the kind of overarching recommendations that we made in our meeting in December, verbatim, cut and pasted from the slides that we used in the policy committee presentation. Results must be transmitted and incorporated into EHRs using nationally defined messaging and vocabulary standards by 2011, orders, using those standards by 2013, and patients having prompt access to lab results in 2011. Then you go to the next slide, this is again a sort of recap of what we did in December. We had some content and vocabulary standards for EHR receipt of lab results in 2011, content, HL-7 2.5.1 version 2, plus the implementation guides of vocabulary, LOINC, UCUM, and SNOMED CT, and associated specifications.

We then had some recommendations that actually were accepted by the policy committee. The content and vocabulary standards piece of it were tabled, and that was all before the rule came out. So the lab piece was adopted, and that is getting labs – aimed at getting the labs better, not sort of part of meaningful use for the most part, the independent labs anyway, to send results using these standards. And we had a number of recommendations with respect to CLIA on interpretative guidance and best practices. Then also, some additional recommendations with respect to hospital labs in particular where you can use the meaningful use and certification policy levers more aggressively because hospitals are potential meaningful users. Then, with respect to the patient access piece, we said to the policy committee that it made sense to look at the meaningful use criteria, which do require sharing data with patients to make sure that the patients are getting prompt access to their lab results. That's, again, just to recap. Before we leave that slide, Micky, did I miss anything on this?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
No. I think that's perfect, Deven.

Deven McGraw - Center for Democracy & Technology – Director
Okay. So then we get to what actually did happen in the meaningful use proposed rule? Well, for both EPs, and that's eligible professionals, so the providers, so the physicians and other providers that are eligible for individual meaningful use payments. That's what's meant by EPs, for those of you who are not familiar with that new healthcare acronym. And hospitals have to incorporate at least 50% of its certain lab tests as structured data. Then hospitals must have the capability to report lab results electronically to public health agencies where the agencies then have the capacity to receive it, and they have to perform at least one test during stage one of the EHR technologies capacity to do this.

Continuing on with more of what's in the proposed rule, this is on the patient access side. Eligible professionals and hospitals must provide patients with an electronic copy of their health information, including test results, within 48 hours, and professionals must provide patients with timely electronic access to their health information, including lab results within 96 hours of the information being available to the eligible professional. That's what's in the meaningful use proposed rule.

Now what's in the certification criteria in the IFR is that the technology, certified EHR technology, so either a system or collection of modules, must be capable of receiving and retaining a lab result in LOINC when the lab sends the result in LOINC in stage one. Then there's a mention of use of LOINC without optionality as a potential candidate for stage two. And so these are just some notes that Micky and I made. It's not necessarily an exhaustive list of questions or concerns, but certainly we notice that there were no content standards specified for either stage one or indicated as a candidate for stage two. No requirement to map all lab results to LOINC in stage one. That's actually made expressly clear in the IFR.

Overall, the requirement to follow any implementation guidance or standards specifications was generally rejected as overly stringent for stage one throughout the IFR, although there are certainly some exceptions where specific standards were enumerated. But, for the most part, the adoption of

implementation guides generally was not part of the IFR. And, in general, there's sort of a recognition that providers and hospitals, those without their own lab information systems, are pretty dependent on – okay. It skipped a slide forward – are pretty dependent on the labs being able to send the results in the standards.

Paul Egerman – eScription – CEO
Deven, this is Paul. I'm going through this. When you said no content standards, that's not the way I understood it. I thought there was an HL-7 standard for receiving the lab results.

Deven McGraw - Center for Democracy & Technology – Director
Maybe I misread, Paul, but there's no content standard specified. It's LOINC. There must be the capability to receive the lab result in LOINC when the lab sends it in LOINC. But there isn't a mention until you get to the public health reporting piece.

Jonathan Ishee - Department of HHS - Policy Analyst
You mean the messaging standard, not a content standard.

Deven McGraw - Center for Democracy & Technology – Director
Thank you.

Paul Egerman – eScription – CEO
So there is a content standard. There's not a messaging standard.

Deven McGraw - Center for Democracy & Technology – Director
My apologies.

Jonathan Ishee - Department of HHS - Policy Analyst
The ability to be able to consume something that is delivered according to the content standard, as long as it is sent to you.

Paul Egerman – eScription – CEO
Right, so there's no messaging standard, but there's a content standard. In fact, I don't have it in front of me, but I think there are actually two content standards for the labs. They gave you two versions, which might be something we might want to comment on. Is that right, Micky?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
What do you mean by two versions?

Paul Egerman – eScription – CEO
I think they said you could do two different version numbers.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Oh, of--?

Paul Egerman – eScription – CEO
Of HL-7.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Right. They did. That was for public – oh, I guess that was for – now was that for the – let me pull it up here, but I can't remember whether that was on the receiving side or whether that was on the sending side. I thought that was on the sending side to public health.

Paul Egerman – eScription – CEO
Yes. I don't have it in front of me, but I think it's on….

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
…5.1 or….

Deven McGraw - Center for Democracy & Technology – Director
That's the next slide.

Paul Egerman – eScription – CEO
I think it's on both.

Deven McGraw - Center for Democracy & Technology – Director
Well, again, my apologies for the mixing up of the messaging versus the content standards. In my head, it's a little hard for me to keep it straight. Essentially, you have to be able to receive; the systems have to be able to receive a result in LOINC when the lab sends it in LOINC. But it doesn't specify HL-7 2.5.1. On the other hand, when you get to the required certification criteria for sending lab results to public health agencies, the technology is in fact required to support HL-7 2.5.1 and LOINC when the result is actually received in LOINC.

Now, of course, when you've got an internal lab system within a hospital that has to make the public reporting, you've essentially, as we can talk about here, got a system that has to have the capabilities to report to public health agencies using both sets of standards that we recommended. And yet, there isn't a requirement necessarily to send the labs using those standards to their customers, to the physicians who are ordering tests from them. So then the other thing that was in the certification criteria was a potentially newer version of HL-7 2.5.1, as well as LOINC, UCUM, and SNOMED CT, or an applicable public health agency requirement would then be potential candidates for stage two.

In other words, it does fall short of what I think of what the standards committee had endorsed back in September, and that we had also put forward in the policy committee meeting in December. And so, I think that this is our opportunity to reinforce why we think this is so important and why labs in particular need the degree of specificity that we recommended, which generally, again, you sort of look at the IFR in total, and there was a bit of an across the board rejection of specificity. Across the board is overstating the case, but there was rejection of specificity and a desire really to sort of, on this theory of sort of keeping it simple and not kind of hardwiring in a lot of specificity in the beginning, and yet, again, we tried to make the case that in fact in the lab area in particular there is a need for specificity.

I want to stop there. This next slide has sort of, again, this is not an exhaustive list of concerns, but ones that we are just teeing up to start the discussion. For one, the results need to be incorporated as structured data, but that actually doesn't specify which standards apply in that case, so again, I would read these off, but I think they're pretty apparent, and I want to stop because I know there are folks on the call who have kind of more experience in dealing with this, both on the ground and I'm sure have opinions on what we might do going forward.

M

Right. And, Deven, just to confirm, your description of the standards was correct. I'm looking at the IFR now. With respect to messaging standards, there was nothing imposed on the receiving end for EHRs being able to receive anything with respect to an HL-7 messaging standard. It was only on vocabulary. Paul, you're right that there were two versions of HL-7 allowed, 2.3.1 and 2.5.1, but that was for the requirement for public health reporting, which is a requirement on the hospital systems reporting for biosurveillance or for lab results … public health.

Paul Egerman – eScription – CEO
And this is Paul again. Among the range of things we could comment on, the fact that there are two, for example, on the public health thing because, picking up on what you said, Deven, where there's a request for specificity. Having two is not specific. I mean, two is better than zero, but specific is one. And you should know, I'm cochair of the certification workgroup. We're going to have a meeting in another week or so. It's hard for me to predict what the certification group is going to comment on, but my personal view is consistent with what you just said, Deven, which is that I would like to have seen, in general, greater specificity that was more consistent with our recommendations. The IFR in particular was more towards keeping it simple, doing as little as possible and, as a result, did not advance the entire function of interoperability adequately.

Gayle Harrell – Florida – Former State Legislator
Paul, this is Gayle. Could you make a comment, please, on what the impact of that lack of specificity is going to result in until 2013? Are we going to have records? Are we going to have EHRs developed that are not going to be able to communicate those lab results?

Paul Egerman – eScription – CEO
I'm sorry, Gayle. Who did you ask the question of?

Gayle Harrell – Florida – Former State Legislator
You.

Paul Egerman – eScription – CEO
Okay. I missed that. This is Paul. Let me do my best to answer it. The way I would answer it is the IFR is a step forward in terms of interoperability, and so the issue is, how big a step forward is it going to be? In other words, by defining LOINC, by defining RxNorm, these are steps forward. It would be completely wrong for me to sort of demean this thing and say we haven't done anything. And so the issue is, how big a step forward do we want to take? And so, it's hard for me to quantify, to answer your question, Gayle, as to what I think the impact is. By doing LOINC, by doing RxNorm, the situation is improved. If we did a little bit more, the situation would be improved more.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This is Paul Tang. I wonder if I could chime in on sort of a meaningful use principle that could be applied here, at least as you consider how to approach this. That principle was that we wanted to have the stages, the so-called stages to be on some kind of glide path or roadmap that if you progressively followed that, you would converge on a system that is robust and comprehensive, and can deliver, can support the meaningful use to accomplishing the health outcomes. An example, and the other phrase of that is to try to avoid dead ends.

And I think that impacts the question that Gayle answered and what Paul was trying to say. If it's true that if you follow this, you would be moving a step forward and not going off towards a dead end, that would be a positive. What's an example?

This bears on what Deven was saying. If you say you should exchange structured, and aren't specific about how, then you can imagine the 1,000 flowers, the 1,000 structure. And now trying to apply that principle, will that make the world better off, or be impeding our progress with stage two? I think that's the question you're trying to answer.

When you leave option – so you've already said, and you've heard testimony on both lab and electronic prescribing that says that optionality has increased the cost and impeded the meaningful transmission of this kind of information. Can you do something? Is not doing anything? Is this not enough to avoid that problem?

Paul Egerman – eScription – CEO
Paul, this is the other Paul. That's a good summary because there is a concern. At least I have a concern that some of the optionality may be counterproductive to the incremental process that you just described. For example, if you give two alternatives for doing an interface, so there's two versions of HL-7 in stage one, but then in stage two, you're going to settle in on a single version, well, if in stage one if you're a physician and you use the wrong one, to get to stage two, you've got to undo some work. And so that's what I mean by it being counterproductive.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's exactly right, and I think we're trying to design the "stages" to avoid that because most of the organizations, the smaller practices or smaller hospitals, won't have the kind of expertise on their staff that can help them decide between what seems to be two equal choices.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And we don't want to put them in that position if possible.

Paul Egerman – eScription – CEO
Right.

M
I think it's even more….

Gayle Harrell – Florida – Former State Legislator
This is exactly the point I was making with my question. When I look at small providers, and I look at community hospitals, they make a choice. They're going to have one shot at this. And they're going to spend that incentive money and buy an EHR system. If they do that, and then at the next stage they're not going to meet the next stage's standard, are they going to then be in a situation where they have to upgrade and pay more money?

Paul Egerman – eScription – CEO
Right.

Gayle Harrell – Florida – Former State Legislator
They don't have the staff to do this on hand. The interfaces that I can tell you how expensive, having had a lot of small doctor practices talk to me recently about the expense of interfaces that the electronic record vendors are charging to link with an HIE in order to be able to do this. If they can't do it within their records, are we not really creating a worse problem?

Paul Egerman – eScription – CEO
Gayle, you raise some good points. I don't think we're creating a worse problem, but we're not doing as much as we can to solve the problem. You're looking at it from the standpoint of the small physician. But if you could also look at this from the standpoint of a commercial lab or possibly a hospital, maybe you have an independent laboratory who wants to do the right thing, and they want to send their lab results according to the standards that are in this document. Well, since the document provides two standards for choices, that means the lab has got to have two different methodologies to communicate with the physician group. That's not great.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Just a clarification, it doesn't say that they have to use either of those two standards for communication to the physician group. There is the hope that there'll be sort of an economy of scope here. But if you make that requirement for the public health reporting, that that's what they'll implement.

Paul Egerman – eScription – CEO
Yes, but the leap of faith that I was taking, Micky, was suppose that they do what we hope they'll do, which one are they supposed to use?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. Even then, there's no implementation guidance, so you even have that variability. Gayle, in answer to your question, I mean, I think in many ways it's been left completely wide open. And, in a way, you could argue that it will set us backward or impede progress toward the next stage of meaningful use in the following way that we are encouraging practices and hospitals to go out and get electronic lab results delivery in stage one because they're saying that 50% have to be structured. But we're not giving them a standard for how that gets done, and so you're encouraging them to essentially embark on the most inefficient way of doing that right now, and then forcing them later, if you think that's going to happen, to undo all of that and move toward a standard, which will be very, very difficult, and would put us in a worse position than we're in today in many ways.

Gayle Harrell – Florida – Former State Legislator
I think that … in our recommendations, in our letter, we need to make that very clear.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes. Micky, this is Jonah. If I could put a point on that, if you look at the payout matrix, at least for Medicare, and the expectation that the $44,000 could be paid for the first two years in calendar year 2011 and 2012 for this where lab is one of the only kind of functional HIE criteria that are going to be required to meet meaningful use. I think e-prescribing is the other one, at least for ambulatory care providers. I mean, if we look at this from a market perspective, the mad scramble is going to be to get lab interfaces done in two years. If you just look at this payout matrix, that's what the provider community is going to see.

And if we are not creating an incentive structure that would reinforce having structured both content and messaging standards, then we're essentially going to be requiring nothing other than just get an interface however you can. Get it into your system however you can. And we will have lost a significant opportunity to standardize.

Paul Egerman – eScription – CEO
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I'll just say what Gayle's point is in a different way. A lot of the smaller providers, hospitals and physician practices, are essentially going to bet their practice on their choices for stage one. I think we better be careful not to put them in that position, like we've been describing.

Paul Egerman – eScription – CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve. A couple of thoughts … first of all, the technical details of this are above my pay grade.

Deven McGraw - Center for Democracy & Technology – Director
Me too, Steve.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I'm not embarrassed to say that, but when we had our hearing, a few things that I remember hearing, we had multiple EMR vendors and/or lab providers say that numbers like $10,000 an interface. Even if in today's world before the ARRA stimulus money starts to flow for this that you could have a multi-month delay from the time of a request being put in for an interface to the time that someone would actually start working on it. Now that's before you have the entire industry scrambling to do this. The meaningful use dollars get paid out to eligible providers and/or eligible facilities, so hospitals.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
So they're just going to go – I mean, I don't know about large, sophisticated health systems that have 8 hospitals or 70 hospitals in a system, but a one or 2 hospitals, you might as well in some ways almost lump them in like a small physician in some ways. But the doctors, the small groups are going to go out and buy prefab EMR programs to try to comply with this. So how does this work with the NPRM that if there's all these different points in there? If you comply with everything, but you're not exchanging 50% of lab data in a structured format in 2011 or 2013, whenever this kicks in, does that mean it's all or nothing? You get all those different elements to quality? And if you don't hit one or two of them, you don't get any money?

M
That's right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Because if that's the case, then there's not going to be much money going out the door because there is no way in the world that people are going to comply with all those things just because they can't, because a doctor is never going to know what LOINC and SNOMED CT and UCUM are. They're never going to know what that is. Most of the clinical people in a hospital, most of the tech people in a hospital aren't even going to have to know those detailed things. It's going to be a subset of them that work on it.

Just for this one little piece, I guess I have real concern that this is really a vendor community and an IT community imperative to make all this stuff somehow work. And yet, the ultimate carrot in this was the

ARRA dollars, so I have a lot of concerns about how that's worded. No concerns that we're not making progress. I think we're making progress. This is good, but have I expressed adequately enough why I think this could really run into a failure of sorts?

Paul Egerman – eScription – CEO

Yes. This is Paul. I think, Steve, you did a very good job. I especially like your comment, this is really like a vendor in an IT community issue because it really doesn't have to be visible to the physician or to the hospital. This is a plug you put into a socket. You don't need to know whether it's RJ-11 or RJ-45. You just plug it in, and it works. That's the long-term vision of this. Because it's a vendor and an IT thing, we can be more specific. In other words, it's not putting a burden on the purchasers to be more specific. The burden is on the vendor and the IT community. And it's not a particularly big burden either.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO

This is the other Paul, Paul Tang. Steve, this is, I think, actually one of the benefits of the Recovery Act, of HITECH, because this is something that the industry and the user community have needed. These are things that the user community have needed, but the vendors have not found it in their best interest or priorities to comply with, i.e. the standards. And we do need this as a community, and so I think this actually raises the bar for the entire – it's really a public infrastructure, and it's the vendors who need to comply with this on behalf of both the direct users, the providers, and their customers, the patients.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

And so my last point, and then I'll step back because some of you have a lot more experience in this, the tech part of this, is then if we have an opportunity for the February 17th policy committee to offer input, and I am sensitive to the fact that it's not on the government's best interest for all these different points to say, to qualify things, like you must do X when available or when possible, because if you put all these when available, when possible, then people are just going to say ignore that one, ignore that one, ignore that one. So I understand that. I understand the government and the taxpayers' needs and desire to want to get a bang for the buck on all of this stimulus dollar.

But I guess I would, in some way, have the information exchange workgroup offer the observation or the input about the real importance that these other subsidiary and necessities actually are done, or else what you're going to have happen is people will go out and buy stuff. A large percentage of them will not truly qualify as meaningful users, and they'll feel that it was a bait and switch. That they tried in good faith, and it didn't happen, and it's not their fault. I'll shut up because I made my point.

Paul Egerman – eScription – CEO

Those are excellent points. This is the other, other Paul, and I think those are really excellent points. I think that you're making points about a description of like the reasons why this is an important issue. And so I think we all are, in some sense, in a concensus that this is an important issue. I think what we need to move the discussion to a little bit is what are the specifics as to what we're going to recommend. In other words, what I heard from the policy committee meeting is just saying we're very unhappy about something, we want something changed isn't the right approach. What we have to do is be extremely specific as to what we recommend.

I'll just sort of throw out a proposal is, having listened to this, I can think of three things to specifically recommend, and these, unfortunately, would be within the IFR. To do it right, within the IFR, I think you have to do something small, so the recommendations, the three things I can think of off the top of my head. One would be where the IFR provides for two interfaces for HL-7, it should only provide for one. That would be one recommendation. The second recommendation would be, if there is no content

standard for receiving laboratory results, there should be. That was the second recommendation, and so whichever of the two that is chosen, that should be done for stage one.

The third recommendation that might be a little bit of a surprise is to say, well, you know you've got the standard for sending laboratory results to a public health organization. Well, that same standard should be used by community hospitals whenever it says lab results to a physician group. Remember, if I remember our hearings correctly, most of the lab results at least for physician groups really don't come from commercial labs. They come from community hospitals. So if we put that forward as a requirement, because it's already there from a different purpose, that would actually help us take a bigger step forward because then they would be required to send their information using LOINC. And so that would help a fair amount.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I think those are really useful, Paul. What do other people think of those recommendations?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
This is Jonah. I think some of them are right on. I think, in terms of the content standards and requiring the same content standards, especially LOINC for public health reporting and for ambulatory reporting of lab results is right on. I'm not as convinced that the messaging standards should be the same. I think they should be based on the same version of HL-7, but in terms of the content, public health in terms of syndromics and surveillance and the kind of lab reporting that's required on the public health side, they have different kinds of requirements for what should be in the message, other than just the content standard. Things like a person's address, which most ambulatory care providers or labs may not have in….

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I would caveat that by saying the content standards, when it comes to things like LOINC specifically, absolutely should be similar for public health and ambulatory lab reporting.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
What do you think about number three for requiring that community hospitals have a messaging standard for delivery of results to the ambulatory physicians?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes, absolutely.

Paul Egerman – eScription – CEO
Yes. Tell me what you think about that, Micky? In other words, I know the whole package is still short of where you would like it to be, but I'm just trying to take a bigger step forward.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. No, I agree. I actually agree with that. I think that Jonah raises a very good point, which is why I don't know the history of why there are two versions of HL-7 there, but I suspect that it's because of what Jonah was talking about, that the 2.5.1 implementation guidance was pretty specific by design, but that public health has some other requirements in there that you wouldn't expect to have every message have to have for regular, you know, the routine ambulatory results delivery that happens every day.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Is CDC PHIN based on 2.3.1? Is that why they're saying it?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Excuse me?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Is the CDC the PHIN, the public health information network, I think that's what it's called, that standard, does anyone know if that's based on version 2.3.1?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I don't know.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
That may be why it's in there.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me also chime in on what direction this conversation is going. This is Paul Tang. I think this would be a great service to all providers, and especially for the smaller providers because this really decreases, essentially decreases the cost and increases the value of having these EHRs because lab is a tremendous value, both to the providers and to the patients. And if we can do something about a consistent standard, that will really decreases costs, increase value.

Paul Egerman – eScription – CEO
Yes. This is Paul Egerman. The proposal also doesn't really introduce anything new to the IFR. It sort of like rearranges the furniture, you know. It sort of says, well, you've already got these standards and these things in place for these other purposes. We want you to add certification criteria to use these things for these purposes also.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Egerman – eScription – CEO
The reason why that's important is the sense I got from the hearings was that we can make tiny changes. We can make one percent changes to the IFR. We can't introduce something new. So I'm not introducing anything new. I'm just saying … rearranging the furniture. I'm just saying certification criteria to take this stuff that you already said you're going to adopt, but to use it for other purposes also.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Egerman – eScription – CEO
Although I am subtracting something. If I could, I'd like to remove one of the versions, but I also think you can subtract. It's easier to subtract, I think, than it is to add.

Gayle Harrell – Florida – Former State Legislator

This is Gayle. I think they were very specific that you couldn't add anything that wasn't already pretty much there. You could amplify slightly, but I would not think there's any problem in deleting.

Paul Egerman – eScription – CEO
Yes. I think this is consistent with the direction we gave them, and I think it would advance it or advance us closer to our goals.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I thought Jonah and Micky were saying the 3.2.1 is potentially useful, so taking it out without understanding why they put it in may be….

Paul Egerman – eScription – CEO
We have to research that.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Yes, that's the concern I would have on that as well.

Deven McGraw - Center for Democracy & Technology – Director
Yes. This is Deven. I think we can look into that and explore that with Doug Fridsma and Farzad and others at ONC who work so closely on this rule and find out what that was in there for. What about if in fact the public health reporting requires the other version, but in fact with respect to reporting of lab results to providers who have ordered labs, couldn't we be more specific on the version that needs … for that purpose?

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Right. I mean, the standards committee had recommended the 2.5.1 with implementation guidance.

Deven McGraw - Center for Democracy & Technology – Director
Right. That's right, so in other words, I think what we're saying is the capacity to support both versions may need to be present so that you can do both public health and reporting of results to ordering providers. But in fact, when you're sending those results to the providers, EHRs, it ought to be in 2.5.1. Does that make sense?

Paul Egerman – eScription – CEO
Yes. I'll alter my proposal. Item number one, I'd say to reduce it from two to one if possible. In other words, based on some further evaluation, but the other two are still there to establish a single standard for, I guess it's called, EPs and hospitals to receive the laboratory data. And the third one is to use the same standard, if possible, for hospitals to send to physicians.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
In the format of our comments, I think the most important piece is the rationale behind this recommendation is that we feel it is an important way to improve the value to the providers and patients and lower the cost.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And the other piece is, and we're trying to avoid – I don't know how to say it, but avoid the dead ends and costs for rework in following stages when the specificity is not adequate in stage one.

Paul Egerman – eScription – CEO
That's exactly right. And by putting it in the certification criteria, physicians who buy systems in stage one will have the capability to do whatever they need to do for both stage one and for stage two without rework for laboratory data.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Gayle Harrell – Florida – Former State Legislator
I think that's critical.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics
This is Marty LaVenture. We'll have to check further, but the CDC Web site shows PHIN reporting requirements with HL-7 2.5.11.

Deven McGraw - Center for Democracy & Technology – Director
Maybe it was a typo.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We can make that a recommendation too. We should remove all typos.

Deven McGraw - Center for Democracy & Technology – Director
I mean, obviously I don't know for sure, and we will definitely look into that.

Paul Egerman – eScription – CEO
Yes, I thought there was one there.

Deven McGraw - Center for Democracy & Technology – Director
It could be.

Paul Egerman – eScription – CEO
Where it's confusing is when you look at the IFR, there's a very long, actually well written textual description that describes what their basic thought process was. But then there's a bunch of stuff right at the end that is the real certification criteria. People tend to look at the tables and everything … used at a lot of our meetings, but it's really the stuff at the end that you've got to wade through all the detail, and I believe there is certification criteria there at the end.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics
This is again Marty LaVenture. They do show – there is one 2.3.1, but … about 15 message requirements are all 2.5, so it's clearly one out of a very large number is still 2.3.1. Most are at 2.5 for their specifications.

Deven McGraw - Center for Democracy & Technology – Director
But there are still some specs for 2.3.1 for CDC reporting?

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics

There is one that's listed, but again this is a little bit older document, so clearly they are moving towards 2.5, and that may have been already updated. But there's at least one lagging at the moment.

Deven McGraw - Center for Democracy & Technology – Director
Well, I think we've come up with some very – this is Deven. By the way, I want to applaud all of you for saying who you are before you speak. It's very helpful to the members of the public who are on the call. But I think, Paul Egerman, thank you very much for crystallizing those three. I think we're coalesced around them, unless I'm missing an objection out there.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
This is Jonah. If we could just reiterate what those three are. I'm looking at the current slide that's up.

Deven McGraw - Center for Democracy & Technology – Director
It's not on the slides.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Okay. When I see just the second bullet of stage one and the recommendations, oh, no, back where you were, but the recommendation was to require, I guess it's EHs, eligible hospitals to send lab results using the same standard that certified EHR technology must be able to receive it in. I would suggest that we reinforce that recommendation. Right now, the way I read the NPRM is that states couldn't even make that recommendation. They couldn't even make that meaningful use criteria. They couldn't add that because, as I understand it, if a hospital, an EH qualifies for Medicare, you automatically are qualified for Medicaid, so you can't add that kind of criterion to an eligible hospital for a state Medicaid agency.

Paul Egerman – eScription – CEO
This is Paul Egerman. First of all, it's actually my recommendation number three, but that's a minor point. The most important point is the recommendation I'm making though is actually not for the NPRM. It's not for meaningful use. It's for certification criteria in the IFR. In other words, we want to say all of these hospital systems have to have the capability when they send laboratory data to do it in the same way these other systems are supposed to be able to receive it, because some hospitals, for example, don't send laboratory data to physicians. But the software has to have the capability. That's the best way I could clarify what I was recommending there.

Deven McGraw - Center for Democracy & Technology – Director
Paul, this is Deven. You stopped short of saying that as a meaningful use requirement, those hospitals that do have in-hospital lab systems would actually have to send the results using the criteria that have to be in the system.

Paul Egerman – eScription – CEO
Yes, I stopped short of that. I was thinking about doing this simply as certification criteria. Now if you disagree, I'm certainly open to hearing that. But the reason why I was stopping short was I just have a sense that it's hard to add meaningful use criteria, but it's going to be a lot easier to add IFR and certification criteria.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
But doesn't that require that the certification, that the scope be expanded then to hospital systems?

Paul Egerman – eScription – CEO
No, because, in my opinion, there's not a requirement that everything in the IFR be represented in meaningful use. There's a requirement the other way around, right? Everything in meaningful use has to

be in the IFR. But it's not vice versa, and so you could put stuff like that in here, whether it's a good justification because just like you could put stuff in that's related to privacy or security. Even though it may not be mentioned in the meaningful use criteria, you could put in something related to interoperability because those are major functions that are called out in the legislation.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
This is Jonah. Could we possibly suggest both, that we insert it? We recommend inserting it into the IFR and into meaningful use.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This is Paul Tang. Unfortunately this was the problem that this group had with the whole lab situation. The lab itself isn't covered by meaningful use. I could see how, if you followed Paul Egerman's logic, if we require the certified EHRs to be able to receive it in such a way, low and behold the hospital EHRs would have to be able to do that as well. And we would at least start paving the path so that if your own EHR receives it with this kind of structure following these kinds of standards, one would hope that your output the lab test from your lab systems consistent with those standards. Do you know what I'm saying?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Paul, how are they able to require it for public health reporting then, or was that not a part of meaningful use either?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The public health reporting is the provider has to use an EHR that is capable of sending that. Then later, in future years, go ahead and send it according to these standards. That's still on the provider side.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I don't think so. Isn't there a hospital requirement to report to public health?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Yes, but not….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I see what you're – so these are both backend ways of – what we don't have, I don't think we have the lever over the hospital's lab system.

M
Right.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I talked to a number of hospitals who believe pretty strongly that they are required to deliver directly to public health.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Through their EHR, you see.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Through the hospital system.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Through the hospital's EHR or however they choose to get the information there because….

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I don't think they see it as different. I mean, if you talk to Beth Israel or any of those hospitals, they'll say we deliver, you know, when we report labs for biosurveillance or whatever to public health, it is exactly the same source system as we use to report to deliver results to ambulatory physicians because it's not – they're responsible for sending all of their labs, not just labs that they perform just for patients in the hospital. It's for all the labs that they perform.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. It's indirect, and someone like Beth Israel is proactive in both complying with the standards and getting data to where it needs to go. The reluctant hospital would not – I don't know that we have a jurisdiction over the reluctant hospital as it administers its lab system. Do you see what I'm saying?

Paul Egerman – eScription – CEO
This is Paul Egerman. I understand the desire to put it into meaningful use, but there's another problem of putting it into meaningful use, which is, if we put it into meaningful use, there are a lot of hospitals who already have interfaces in place that are non standard. And so if we put it into meaningful use, they're going to be screaming and unhappy that they have to rework this stuff that is already working a time when they've got tons of other things on their plate that they have to do. We're sort of adding a burden to them.

If we do it the way I'm suggesting, we're simply arming them with the capabilities to do it because what we really should be focusing on for all this interoperability stuff, at least right now, is sort of like the adoption process. I think it was Steve who expressed concern. How will you get people to buy these systems and actually use them and qualify? This is going to – what I'm suggesting will improve their ability to qualify?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
You could make it a requirement for new interfaces, which would have the effect of their having an incentive to take down the old ones and migrate everything to the new because, for most hospitals, they've got a long list now of new interfaces that they're going to have to accomplish, and without a standard, we've kind of left them, I mean, one CIO told me that we've been left out, hung out to dry by ONC and CMS on this because they're required to deliver labs, but now they're having to negotiate with each EMR vendor for their own unique, particular standard in order to get this done, and getting a lot of pressure from their physicians who want this done.

Paul Egerman – eScription – CEO
Let me ask a question. What I'm….

Gayle Harrell – Florida – Former State Legislator
And the cost is huge for … interface.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right, because it takes a lot of time, because each one is customized.

Paul Egerman – eScription – CEO
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
If we do the standards for the receiving end on the EHR, aren't we helping that problem? I realize it's not direct.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I don't think so. What ambulatory physician has any ability to dictate what standard a hospital source system delivers to them?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
They don't, but if their product, if all EHR products get certified to be able to receive labs using these content and messaging standards, wouldn't that influence the…?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
…receive any of the other ones too.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
But that's the problem with the market today. They are certified to receive 2.5.1 and they don't.

Paul Egerman – eScription – CEO
Actually, I don't think they are certified….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes, well, and so my whole problem is I don't know where our scope, you know, that's the problem you all presented. This whole lab problem is missing from the legislation.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I guess I'm still not understanding why we think we have authority of public health reporting and not this because the reality is that they're not going to report for public health out of their EHR. It's going to get reported out of the very same system that we say we have no authority over.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But the difference is, that's their choice. We asked for the EHR to be capable of reporting to public health, and it may be their choice to have it come out of their lab systems. Do you see what I'm saying?

Deven McGraw - Center for Democracy & Technology – Director
Yes. It's also….

M
But it's the same results.

Deven McGraw - Center for Democracy & Technology – Director
It's also the reality that the requirement to have the capability to send lab results to public health agencies applies to hospitals whether they have a lab information system or not across the board.

Paul Egerman – eScription – CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director
As opposed to imposing a requirement to report lab results to physicians out of a lab information system within a hospital that's only going to apply to those hospitals that actually have in-house labs.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. So let me just ask. If you are a hospital that has a lab, which is most hospitals, and you deliver to the ambulatory side, they are required. Do we agree that they are required to report on all labs that they perform, not just labs that they have performed for the inpatient side? Do we agree with that?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That they are required to…?

Paul Egerman – eScription – CEO
That's probably right.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
So if they are required to report on all labs, how would labs that they are performing for ambulatory physicians get into their EHR in the first place? I think there's a disconnect in the logic that was being applied about where we have authority. It seems to me, you either require them to report or not require them to report, but not … public health.

Paul Egerman – eScription – CEO
This is Paul Egerman. Here's another way to look at this debate that we're having right now. It goes back to the comment Steve made. Steve made a lot of these issues are really like vendor and IT issues. And so, the proposal I put forward, by putting it all on the certification side, puts the burden all on the vendors and the IT people in terms of getting this part done. The argument about meaningful use is really an argument, do we want to put a burden on the hospital, right? That's the question at hand.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Or do we want to put a responsibility on the hospital?

Paul Egerman – eScription – CEO
Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
We're putting burdens on everyone, right?

Paul Egerman – eScription – CEO
Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
And we're giving them millions of dollars.

Paul Egerman – eScription – CEO
Right. And all those comments are fair, and so that's really the question. I guess I really don't know the answer. I personally think the part I said will take us a big step forward, and it'll be easier to sell. But I don't have any problem if you want to take it even another step forward.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
It sounds like the question on the table is whether to extend this to meaningful use. It seems that we're all agreed that for the IFR, we should make that part of the recommendations. Is that fair?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
As part of certification of EHRs, correct?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Egerman – eScription – CEO
Yes.

Gayle Harrell – Florida – Former State Legislator
Yes. I think there's concensus on that.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Are there other thoughts? Do people have different thoughts on this question of extending to meaningful use or the NPRM?

Paul Egerman – eScription – CEO
This is Paul Egerman. The main comment I had earlier is if you want to extend it, you've got to be careful, at least in state one, that it's not done in such a way that it causes disruption of existing non-standard interfaces because, I think, probably for vendors like if Epic is still on the phone, but vendors like Meditech or Cerner who have hundreds or thousands of these in place, they're just not going to be able to redo them in state one.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. That's what I mean. Is there a logic to say for the hundreds or hundreds of thousands that they're going to implement going forward, because we've directed them to and put money on the table and given everyone incentives to, do you want to try to get some structure around that, or do you want to just continue the madness?

Thanos Tsiolis – Epic Systems – Software Engineer
It's Thanos speaking from Epic. I do agree that it would be wonderful to have the ability to say anything new should use these rules, and we've spoken in the past. The most specific the better, so messaging, what we said in the past, HL-7, a particular version would be great, and I personally like very much the way it's mentioned for the use of the vocabulary. LOINC should be able to be received if sent from the originating lab, so this way you do not make existing facilities change what they have working, but anything new is tight and should have less implementation costs if the standards that we are putting forth are going to be followed.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
This is Jonah. I agree with that. We do have to be very careful, Paul, to your point, about requiring reengineering of things that work today. But if we make some assumptions about where we are today in terms of lab ordering and resulting, and you take away, first of all, sort of the large, national players,

which represent a fraction of the market where most of it happening is in hospitals. Most of them aren't reporting most of their labs electronically. Most of them will be asked to do so in the next two to three years. If we don't try to encourage some standardization in those two to three years, especially the first two in stage one where much of the work is going to be done, we will have missed the opportunity to standardize labs.

M
I'd just like to point out that we just heard Epic say that they're going to reduce their prices on interfaces if we impose the standard.

Deven McGraw - Center for Democracy & Technology – Director
We did?

M
Just joking.

Thanos Tsiolis – Epic Systems – Software Engineer
The implementation time will be reduced.

M
Will be reduced, right, absolutely.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's a very important statement. It still goes back to the increase value, lower cost. That's the value proposition.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay. Where are our levers? Clearly, you've got to keep the certification of EHR levers intact, and is there anyone from ONC that can help us interpret what kind of jurisdiction we have in the meaningful use side, or who would we ask?

Jessica Kahn – CMS – Project Officer
Just a point that meaningful use is a CMS rule … ONC rules.

Deven McGraw - Center for Democracy & Technology – Director
Jess, help us out here if you can.

Jessica Kahn – CMS – Project Officer
I think you had it right when you were saying that – and again, this is my interpretation that the certification criteria, it was a decision that they should mirror what's proposed for meaningful use. It doesn't mean that they have to be limited to that, if that was your question.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
No, it's more that so they, right now, are not talking about the lab systems themselves.

Jessica Kahn – CMS – Project Officer
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And I was under the assumption that we, on the meaningful use side, don't have the scope to be able to impose something on the lab systems.

Jessica Kahn – CMS – Project Officer
Right. Our OGC said that meaningful use criteria are for the electronic health records and the providers that use them, not for any of their ancillary business partners.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Right.

Jessica Kahn – CMS – Project Officer
So you cannot use meaningful use criteria that are tied to the EHRs and what the providers are doing with them to what other partners may or may not want to do because that's out of the control of that person or that institution for whom the incentive is on the line.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think we need to do everything possible to make it in the EHR vendors' and the customers' of the EHR vendors best interest to use these standards. One of them Epic has said. The more standard you have your lab systems, the lower your implementation costs for the interfaces. We now, as customers, have to go back to the – I think we have to use the market forces to go back upstream to the lab source systems.

Deven McGraw - Center for Democracy & Technology – Director
Right. I think the frustration here is that in the case of hospitals, which are a part of the sort of meaningful use umbrella, they're not ancillary providers. When they actually have the lab in-house, there's this – I think what I sense is a desire to try to stretch this a little bit because if their EHRs have to be certified to report results to public health using standards, and we can go the next mile and say, from a certification standpoint, the capability ought to be built in to provide the results using those same standards to your ordering customers, physicians, than is the next step, again, where you've got a hospital with a lab inside of it, and according to Micky, no clear distinction really between the LIS, lab information system, and the EHR, whether we can use the meaningful use criteria for which hospitals are in that universe of reachable candidates to essentially require the reporting of the results using the capabilities that have to be in the certified system.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
This is Paul Tang. I'm following you, Deven, and I think there are two avenues. One, there's a precedent because we did that with the patient access, so we made a precedent of the hospital finding a way to give patients electronic access to their data. The other category we could invoke this in is the care coordination. So we need to be able to have them pass on information, including structured lab results, to other systems. Maybe that is the entrée. It clearly is in everybody's best interest.

Deven McGraw - Center for Democracy & Technology – Director
Yes. This is Deven again. We recognize that we don't have an ability, through meaningful use or certification, to reach the independent labs.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Deven McGraw - Center for Democracy & Technology – Director

Because we have the opportunity to do so with hospitals, do we take that step because it's an opportunity that can take us further down this road to standardization where we don't have those same tools with the independent labs? With the independent labs, the most we can do is try to stretch them with CLIA, and guidance can only go so far.

Kelly Cronin – ONC HIT DHHS – Director
Right. This is Kelly. I'm sorry to join the conversation so late, but in terms of additional levers, and … regulatory guidance you're already mentioning with CLIA, but I'm wondering too if there's additional state authorities, and maybe Jonah could speak to that.

Deven McGraw - Center for Democracy & Technology – Director
But Jonah made the point, Kelly, that if a hospital meets Medicare meaningful use criteria, whatever additional that a state puts on for Medicaid is irrelevant.

Kelly Cronin – ONC HIT DHHS – Director
If they choose to just go for the Medicare incentive, yes.

Deven McGraw - Center for Democracy & Technology – Director
No, they can use the – I mean, if I'm reading the meaningful use rule correctly, I read it to say hospitals have the capacity to get financial incentives from both programs, but can get them by satisfying just Medicare.

Kelly Cronin – ONC HIT DHHS – Director
Right, right. Okay.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I read that too.

Kelly Cronin – ONC HIT DHHS – Director
That's a point of public input though, and that's a point back to the committee.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
And the other piece is there's also language that says that the states can add to the … so I remember both….

Jessica Kahn – CMS – Project Officer
Can I explain what that means though?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Yes.

Jessica Kahn – CMS – Project Officer
What we meant by states may propose to CMS subject to prior approval, additional meaningful use measures not things that would change the functionality of an EHR because that kind of renders the whole idea of having a standard certification criteria moot, but that they might make the meaningful use definition specific for their state. For example, one of the criteria is being able to list, make a list by certain conditions, generate lists of patients by certain conditions. So if you are a certain state that is struggling with obesity or diabetes or HIV prevalence, you might specify that these are the kinds of things – those specific conditions you want your state providers to be able to generate from their EHRs, or you want them to speak to a specific immunization registry. But it's not that they could change the criteria to

go beyond what is in the certification criteria because that just throws a wrench in the whole idea of having people being able to rely on when it says it's certified, it can do X, Y, and Z, and that's good enough for me and my state.

Deven McGraw - Center for Democracy & Technology – Director
Right, Jess. This is Deven. But I think we were already put on the table that the certification criteria would in fact include a capability to send lab results to physicians using those standards.

Paul Egerman – eScription – CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director
So we wouldn't be piling on. I mean, we've already crossed the certification threshold. Paul's analogy of rearranging the same furniture or maybe using the same couch for two things.

Jessica Kahn – CMS – Project Officer
Right. That's true. If it ends up in the certification criteria, then a state could propose to CMS that they would like to add that to their meaningful use, so you'd almost have levers coming from two directions.

Deven McGraw - Center for Democracy & Technology – Director
But even for hospitals? I guess I think that's unclear. I sort of read the statement about sort of that hospitals could meet the Medicare criteria and be eligible for both programs to kind of trump.

Jessica Kahn – CMS – Project Officer
That's only for the hospitals that are dually eligible for both, which is only certain acute care hospitals. It's not the critical access, and it's not children's hospitals. It's only those that are eligible for both where the Medicare floor definition, the floor definition for meaningful use would be deemed for Medicaid. But there are a number of hospitals that are not eligible for both….

M
But most probably are, right?

Jessica Kahn – CMS – Project Officer
Yes. Probably. It depends, but yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
It seems there are two issues. The one we're trying to figure out now is what sort of authority do we have with the hospitals, right? I think, to Paul Tang's point, it seems that there's a concensus that this would make everything better if we could do it, and we're just trying to figure out what's the lever.

Let me just ask again just a specific point because I just want to understand how we've drawn the lines of the authorities here that for a hospital, let's just pick any hospital. The University of Florida in Gainesville that does a ton of labs, they have their own huge inpatient population, and they're doing labs for the patients who are in the hospital, but they also deliver results out to the community. Is the public health reporting requirement for meaningful use for the University of Florida Hospital in Gainesville, is it the requirement that they report to public health every single lab that they do, or just the labs for the patients that are in the hospital?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

Wait. This is Steve. It better not be every single lab. That'd be obscene. It's only for reportable conditions probably, so gonorrhea.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
That's fine. Reportable conditions, but reportable conditions for all the labs that they conduct or just for the ones who are in the hospital?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
It should be for all the labs. Every reportable condition that they generate a result for, and it's positive or abnormal, meaning it has … those should be reported. The lab doing the test has the burden of reporting, as I understand it….

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. The reason I'm saying that though is that so now whatever authority has been applied for the public health, for the public health requirement has extended to their lab results delivery function to the community. Right? It's not just about what's in their EHR because they are not going to be putting in the hospital EHR lab results that they have done for a community physician. Those are not a part of a hospital EHR.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I don't know. People who come to the hospitals where I work who have outpatient laboratory results, I can look all of those up through our EHR, so the laboratory data system that contains all of the results that they have created for patients who have come to their facility are all accessible to me within their walls as a clinician, so I think they are. I think all of that is part of their "EHR" in that lab data is a subset of the EHR.

Paul Egerman – eScription – CEO
And so if I'm hearing your point right, Micky, this is Paul Egerman, what I'm hearing you're suggesting is, well, gee. The labs already have a meaningful use requirement to report all this stuff using these standards anyway.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Egerman – eScription – CEO
And so since they have that, you're sort of taking my IFR argument of rearranging the furniture, and you're actually applying it to the meaningful use side.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes.

Paul Egerman – eScription – CEO
We're going to take that same requirement, and just add something a little more to it.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Egerman – eScription – CEO

I guess, as I listen to you, my reaction has changed. My view is, yes, let's go for it as long as we are very clear that it's only new interfaces to certified EHR systems … so that it's very clear that it does not require reworking anything.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Egerman – eScription – CEO
I don't know whether or not CMS will accept it, but I don't see any damage in giving it a shot.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
It seems that it's using the exact same authority for public health, but if you could do it for public health, you can do it here as well.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let mer still see if I can try to understand your logic. I see where you're going, and clearly, no matter who produces the lab results, if they're going to do it for part, like just the reportable, you might as well do it for your whole stream. That I get.

I still don't see how the meaningful use objective places responsibility on the LIS. It places responsibility on the hospital to cause reportable lab test results to be transmitted to public health following a certain standard, and that information comes out of the EHR. That doesn't say how it gets into the EHR. It says how it gets out of the EHR, or whatever clinical systems you choose to transmit this required information. I'm not sure it actually does force. It would encourage. It doesn't force the LIS at the hospital either wrote or maintains, produce their output at the interface level using these standards.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Maybe we don't really want that at the end of the day, right? I guess I'm just suggesting that whatever authority we thought that we had to require that they report it in a certain way to public health seems to me to be the same authority that we could use to require that they report it to ambulatory physicians for a certain standard. Now whether that means it's in their EHR, as per Steve's point that in his hospital it may be in the EHR. We can leave that to the hospital. At the end of the day, it just needs to get out according to a certain standard.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think I follow your point. Use our lever available to the maximum extent, and it would encourage because it would be in their best interest for people to comply with these standards.

Deven McGraw - Center for Democracy & Technology – Director
In other words, to use that standard for reporting of….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Correct. If they have to do it for another purpose, find a way to extend that to communicating with their other partners.

M
Right.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
The only funny thing is, it's in another function. When they're communicating it to their private community

doc, they're communicating it as an ancillary department, i.e. a lab facility. Then it gets back into, well, I don't know. But what you're trying to say is make it easier for them to just do it the same way.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Well, I mean, I think that's the point of requiring it through certification. It's the same set. I just love the furniture analogy. The same set of furniture used for two different purposes, I think it's yet another thing altogether to say, well, actually, as part of meaningful use, which you actually need to do in order to get your payment, you in fact have to have this capability to transmit lab results to physicians using the standard. And if we follow sort of the way it's phrased in the public health context, you'd have to perform at least one test of your ability to do that. And, ideally, in subsequent stages, you'd be transmitting more of these results using the standard ala the incremental approach.

Keeping in mind that while the public health reporting requirements in the certification IFR say you have to be able to do it using these standards, in fact, if you look at what the meaningful use criteria say, for hospitals, you have to have the capability to submit reportable lab results to public health agencies, and you have to perform a test of it as the measure. That's pretty lightweight if we were to mirror them, same capabilities in the systems, and then the meaningful use. What we're proposing is a sort of similar step forward on meaningful use criteria with respect to reporting of results to physicians, which is going to be relevant for hospitals that have labs that do that business.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. The hope is that if they perform it once, that means it's up and running, and they'll use it. I have a clarification. I did send an e-mail while we were talking to John Halamka and Jamie Ferguson on this 2.3.1 versus 2.5.1 question. The reason is that there is an implementation guidance for immunizations from the CDC that is for 2.3.1, so that's why that has both in there because there is no 2.5.1 implementation guidance for immunizations yet.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
One suggestion to them is to make it clearer.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Excuse me?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
One suggestion to them or to CMS is to make that statement clearer so that people understand what that optionality represents.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Thanos Tsiolis – Epic Systems – Software Engineer
But also, it's Thanos speaking, this is for immunizations, which is a specific type of message. It is different than the types of messages used to report and/or receive lab results.

Paul Egerman – eScription – CEO
Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right, for lab results, I think we're talking about 2.5.1, the implementation guidance.

Paul Egerman – eScription – CEO
Yes. This is Paul Egerman. Immunization is not a lab result.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Thanos Tsiolis – Epic Systems – Software Engineer
Correct, so that explains the last line in the IFR rules that talk about submission to immunization registries. It does not answer our question for submission to public health agencies for surveillance or reporting. There has still two standards there, 2.3.1 and 2.5.1.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes, that's fair.

Deven McGraw - Center for Democracy & Technology – Director
Maybe it makes sense, Micky, to try to sum up sort of where we think we are.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Me?

Deven McGraw - Center for Democracy & Technology – Director
Both of us could try to do this?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. Why don't I start? When I falter, you can pick up.

Deven McGraw - Center for Democracy & Technology – Director
Also, I'll call on Paul Egerman as well since he laid the sort of three pieces on the table for the certification IFR piece.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right. I think it seems like we still have three pieces. One is about, it sounds like we are now talking about perhaps providing greater clarification of why there are two standards for the public health lab reporting piece. If there is indeed sort of a good sound reason for having those two standards, there needs to be some more clarification around it. Otherwise we would recommend having one standard rather than two. The second, I believe, is….

Deven McGraw - Center for Democracy & Technology – Director
Specifying the standard for receipt of results.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Sorry?

Deven McGraw - Center for Democracy & Technology – Director
Specifying standards for receipt of results.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes. Right. That's the second, which we would say for a messaging standard is that 2.5.1 implementation guide that was approved by the standards committee. And then the third, I think, is where it gets a little bit more nuance, which is essentially saying that hospitals should be required to mirror – let me back up. To mirror the requirements that are there now in the NPRM for having the capability and demonstrating the capability to deliver lab results generally to public health, either via the 2.3, 2.5.1, once that gets resolved or clarified, and for all the other results via 2.5.1 implementation guide, which is the same thing that EHRs are getting certified for.

Deven McGraw - Center for Democracy & Technology – Director
Right. I think there's two pieces to the hospital. One is that the IFR has to include the same standards that apply for public health reporting of labs to reporting of results, so that addresses the system capability piece.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes.

Deven McGraw - Center for Democracy & Technology – Director
Then the piece that you just mentioned is the mirroring of creating a meaningful use requirement that mirrors public health reporting for reporting of results to physicians.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Egerman – eScription – CEO
This is Paul Egerman. I think that summary is correct, and it's really important that there be two different groups of recommendations. In other words, there's a group of recommendations on the IFR, and there's a separate PowerPoint stream.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Egerman – eScription – CEO
In other words, an NPRM recommendation because the meaningful use thing goes to CMS. The IFR really goes to ONC.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Egerman – eScription – CEO
But we want to get it all, but that's the best way to describe it. Those are two different groups of recommendations.

Gayle Harrell – Florida – Former State Legislator
This is Gayle. Deven, I think you need to also put in there that on existing systems that this does not apply. It only applies … coming in.

Paul Egerman – eScription – CEO
Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Yes. Thank you.

Paul Egerman – eScription – CEO
That's right. Thank you, Gayle. That's correct. That's critically important for this to be successful.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Paul Egerman – eScription – CEO
That's what we discussed.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Okay. Does everyone feel comfortable with that? We'll obviously write it down and get it back out to everyone.

Deven McGraw - Center for Democracy & Technology – Director
Yes. I took notes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Jonah, Marty, are you still on the line?

Marty LaVenture – Minnesota HHS – Director, Center for Health Informatics
I am. This is Marty.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
What did you do with the LOINC, for example? That wasn't yet – you haven't gotten there?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
It's still there.

Deven McGraw - Center for Democracy & Technology – Director
No. LOINC is part of the – I mean, we focused a bit on HL-7 2.5.1, but we would include LOINC.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Okay.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I'm sorry. This is Jonah. I had visitors here come in that I had to meet with, so I was not tracking the last ten minutes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
It's all taken care of, Jonah.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Excellent.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
You're going to be happy.

Gayle Harrell – Florida – Former State Legislator

And you agreed.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I agreed. All right.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
On behalf of the entire state of California, you agreed.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
I'm glad that's on the record.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Quickly, I restated it once. Deven, do you want to give Jonah a quick, very quick summary?

Deven McGraw - Center for Democracy & Technology – Director
Okay. So there's sort of three pieces on the certification IFR in terms of comments. One being that there needs to be more clarity with respect to the HL-7 version, and that we are certainly disposed to moving towards the 2.5.1, and it ought to be clear that where 2.3.1 is acceptable, where that applies, such as to immunization reporting because it's not clear, and it looks like they're requiring two different versions. For number two, that they need to be clear about a standard for receipt of results, so that would be LOINC and ideally 2.5.1 with the implementation guide recommended by the standards committee back in September.

And then for number three, on the certification side, the hospital systems have to be certified to able to report results using LOINC and HL-7 2.5.1 not just for public health, but also to physicians who order tests from them. Then there's a meaningful use recommendation on hospitals that we want to mirror the current meaningful use criteria that applies to hospitals with respect to the capability to report lab results to public health. They should have a mirror capability to provide the lab results in those standards to physicians, and perform at least one test, and we really want that to apply to new interfaces. Did I get that right?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes.

Jonah Frohlich – HIT at California HHS Agency – Deputy Secretary
Excellent.

Deven McGraw - Center for Democracy & Technology – Director
Now you can feel more comfortable with….

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Who else was on the phone? Steven and Thanos, are you okay with all this?

Thanos Tsiolis – Epic Systems – Software Engineer
Yes, it's Thanos speaking.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Yes.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO

Great.

Deven McGraw - Center for Democracy & Technology – Director
Excellent. All right. A lot of the – we've actually kind of jumped through some of what these other slides were, which were meant to help guide a discussion. We actually got through much more quickly thanks to that sort of initial set of recommendations from Paul.

I think, depending on how much time we have in the meeting to present all of this, that we might reinforce what we said about CLIA, that already got adopted, and some of the pieces. I'm on the slide now, the suggestions that we had to promote better alignment of federal and state rules. This is not dealing with the NPRM or the IFR. And so if we're sort of really cramped for time, we might not be able to raise these.

But I have put them on the slides in the hope of – you know, we have a whole package of recommendations here that are all aimed at moving toward greater standardization in the lab data space, and understanding that there are sort of two prongs to this, not just the providers, but also the labs, in trying to use other policy levers that might exist within the federal government to get us there. But again, we are likely to probably be pressed for time, and I think we're all in agreement that we want to use the time that we have to make the points that we need to make with respect to the NPRM and the IFR.

Paul Egerman – eScription – CEO
Yes, and this is Paul Egerman. Deven, my understanding of that meeting in February is really our focus on making our comments on the NPRM and the IFR.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Paul Egerman – eScription – CEO
And I also would be a little bit concerned that if we start to raise some of this CLIA stuff, which is valuable information, but it would perhaps divert the follow-on discussion. I want to make sure that we fix the NPRM and the IFR.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Paul Egerman – eScription – CEO
I'm sure David will let us come back to the CLIA and the rest of the recommendations at future meetings.

Deven McGraw - Center for Democracy & Technology – Director
Yes. That's a fair point.

Kelly Cronin – ONC HIT DHHS – Director
Yes. This is Kelly. My understanding is that David sort of wanted some immediate feedback on this CLIA stuff, so I don't know who else is on from ONC who could speak to this, but if Jonathan or someone else. I just know, I've seen and heard David say that this is something he really wants some feedback on, and it was slotted for the next meeting.

Judy Sparrow – Office of the National Coordinator – Executive Director
It's Judy. It's really a matter of timing because of this February 17th meeting is going to be devoted almost entirely to the NPRM and some IFR comments from Paul Egerman's group. But I'm working the agenda now. We'll see, Deven.

Deven McGraw - Center for Democracy & Technology – Director
Okay.

Jonathan Ishee - Department of HHS - Policy Analyst
This is Jonathan. We'll circle back with him because we've had some internal conversations with him on this, so I will get you an answer.

Deven McGraw - Center for Democracy & Technology – Director
That'll be helpful because we want to get David what he needs, but make maximum use of the time. We do have a tendency as an IE workgroup to present some relatively complicated stuff, and there's often a lot of questions, so I understand the need to prioritize and get done what we absolutely have to get done in February, which is the NPRM and the IFR stuff.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Does that mean, are we going to be on the agenda for February 17th, or is that still a maybe?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. No, you are on the agenda.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Okay.

Deven McGraw - Center for Democracy & Technology – Director
So get your ticket.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. Okay. That's why I wanted to know, a ticket and hotel room.

Deven McGraw - Center for Democracy & Technology – Director
All right. Taking a deep breath here, so in that vein, I suggest that we move to what, if anything, we want to say in the NPRM and IFR with respect to e-prescribing. I have to confess that after listening to the very good testimony that we got in our e-prescribing hearing, number one, I'm still trying to digest it. But for me, and there wasn't anything that jumped out as needing to be fixed necessarily in the NPRM or the IFR on the e-prescribing side, and that some of the issues that both, if not all of the issues that were raised in the hearing kind of needed some longer-term deliberation on our part. But I could be completely wrong about that, but if we're going to focus on the IFR and the NPRM on e-prescribing, I think that's what we ought to do in terms of our preparations for the policy committee meeting.

Paul Egerman – eScription – CEO
Yes. This is Paul Egerman. I had a couple of comments. One is, independently, I attended a Meditech user advisory committee meeting, which I was invited as a guest so that I could just hear what their advisory committee had to say about the NPRM and the IFR. Much to my surprise, they were very pleased with what the IFR said about RxNorm. They were beyond very pleased. It was like it was a homerun in this thing, so they liked LOINC, but they didn't like that as much as RxNorm. And the reason they didn't like it as much is they were already doing LOINC, so they thought that that was really good. That's just an observation.

But the other observation I had, as I listened through the e-prescribing hearing, which I apologize I wasn't able to be there in person, was you've got this organization, SureScripts, is sort of like what's responsible

for the existing connectivity. But SureScripts is sort of like an intermediary, and we have all the same problems with e-prescribing that we have with the laboratory. There's not a good use of standards. There's not an adherence to a standard.

The reason SureScripts exists is because of the absence of standards that are really being used. In my opinion, it's a dangerous thing to keep going forward because the question I asked SureScripts; they didn't like the question about being too big to fail. As we move forward, if we keep that model in place, SureScripts becomes a monopoly that's critically important to running our healthcare system, and I don't think that's what we want. So I think there's a lot of work that needs to be done here. I don't know that I can necessarily tell you what needs to be done in stage one, but we have a ton of work to do in stage two and three on e-prescribing.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. This is Micky. I think it's certainly true that that is a legitimate policy concern generally about pushing people into a channel that right now has only one provider of that service. I don't know. It's certainly not something that we're going to be able to tackle between now and February 17th. I guess, getting to Deven's point, I was still in digestion mode of a whole bunch of that stuff. But aside from that big issue, Paul, which I agree is sort of a big issue, and I'm not sure how immediately pressing it is, but sort of a longer-term kind of deliberative activity that probably warrants a lot more sort of public hearing and comment on the matter. I'm not sure anything else sort of presented itself for the 17th.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve. There is one other thing, and I'm going to have to admit some inability to comment with specifics on this language in the NPRM. But with respect to what Paul Egerman just said, I mean, we don't want to create the AIG of electronic prescribing, I guess. But on the other hand, it's the one place that right now there is truly a robust bidirectional exchange of information that works on a national level. So I guess I would feel comfortable as a user of the systems coming back to that later and trying to build in fail-safes or other options, if necessary. But for right now, it actually works, and maybe it works because there is one way to do it.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
But the other point I really feel compelled to make, and I'll try not to beat up on the DEA because I already got that out of my system a little bit at the hearing, but as an emergency doc, there are days, 30% to 50% or more of what I prescribe is a controlled substance.

Gayle Harrell – Florida – Former State Legislator
This is Gayle Harrell, and I want to echo that as well. You have pain clinics and surgeons who won't be able to meet 75%.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
And so I don't think this is a….

Deven McGraw - Center for Democracy & Technology – Director
Well, Gayle, sorry to interrupt. This is Deven. It's only eligible prescriptions for e-prescribing. You're not held accountable for what you can't e-prescribe.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept

I know, but as a physician, I just want to point out that if there's a mechanism in place. I mean, my health system is still on Internet Explorer 4. What version are we…? And I don't say that to belittle them. I mean, they've got hundreds of systems that interface with that thing, and so they have to test it, so they don't upgrade every single one, but we are kind of behind.

If I have to carry a thumb drive or some hard token, and I work at four different hospitals, three of them in the same health system that are two different tech platforms, two of them Cerner and one Meditech, and the other one is a different health system all together, they're on like DOS based systems. And I have a hard token that I can carry from property-to-property that somehow works, and then have different workflows for those two different things. I can't emphasize enough that the government does have some accountability, even if they are differently totally branches of the executive branch and different departments. They have an obligation to resolve this in a way that works for all of us who are trying to provide healthcare.

I can't emphasize enough that I have a total, a near total lack of concern for making the barrier really high at the front-end and hope you diminish diversion because diversion will still happen by people who are intentionally wanting to divert. I think we have to have a robust surveillance approach to this so that we can actually know when there are deviations and unexpected patterns in either a prescriber's prescription of stuff or a patient's use of stuff that shouldn't happen.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
I think, I mean, I really would like to punctuate that. If I could be … and hit my shoe on the counter, I'd do it for this one that that has to be fixed, and it has to be fixed in favor of the healthcare delivery system, not in favor of the law enforcement people.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Steve, this is Dave Goetz. I'm sorry. I'm in between hearings, and I deeply appreciate what you're saying. I'd just also never underestimate the ability of government agencies to not cooperate.

Gayle Harrell – Florida – Former State Legislator
This is Gayle Harrell. I also want to point out that in some small communities, I don't know if 75% can be reached because you may have one or two local pharmacies who are independent. What do you do in a situation like that? We have a lot of rural communities where there are no chain drugstores that do e-prescribing. What do you do? I mean, how, for a physician in a situation like that, it becomes damn difficult.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Gayle, that's why our approach has been to go out community-by-community and actually try and make sure they're hooked because if it's going to be end-to-end, you've got to get the ends together to actually kind of cooperate and figure out, do test messages and the like.

Gayle Harrell – Florida – Former State Legislator
A lot of the independents are not going to want to pay fees to SureScripts.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
Actually, in our PBM contract we just did, I believe we've written it in there where we're going to pay the fees in order to try and promote it.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Dave Goetz – State of Tennessee – Commissioner, Dept. Finance & Admin.
But we're unusual.

Gayle Harrell – Florida – Former State Legislator
I think the 75% is a very high standard.

Deven McGraw - Center for Democracy & Technology – Director
Is Paul Tang still on the phone?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I am.

Deven McGraw - Center for Democracy & Technology – Director
I'm on the meaningful use workgroup, but I wasn't able to attend the last meeting. Is looking at these sort of thresholds of use something that you guys talked about?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
We did not finish the work, so we had a one-day meeting, but did not discuss thresholds. We focused our attention on the "philosophical" issues, so I'm not even sure we will get to the threshold pieces, and it's only limited by time. So if you want to comment, certainly pass those comments on. I'll pass them on, and we can deal with that. We do have a call coming up this week.

Deven McGraw - Center for Democracy & Technology – Director
Yes.

Gayle Harrell – Florida – Former State Legislator
Paul, this is Gayle. I'd like that to be addressed because we have a lot of rural communities and small communities where there are no chain drugstores. There are only small, independent pharmacies. And, for the most part, they do not participate with SureScripts. They don't want to pay those fees. They can't afford to.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me see how we can….

Gayle Harrell – Florida – Former State Legislator
Seventy-five percent, you know, you have two or three docs in a small town. You have one pharmacy. People get their prescriptions there.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Let me add that to our list. Thanks.

Deven McGraw - Center for Democracy & Technology – Director
Was there anything else? My apologies for not putting the standard that's in the IFR for medications in these slides. I had NPRM on the brain for e-prescribing. Did anybody else have other issues that need to be raised with respect to e-prescribing and the NPRM and the IFR? We will need to schedule some

subsequent meetings of the workgroup to kind of further digest the issues, including the DEA. Including, but not limited to, the DEA issue that arose during the hearing.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve. I think that this is the one area of this robust and grandiose dream that we all have for health IT and HIE. This is the one area where it is on the precipice ready for prime time. I don't think most of us heard too much that was new or earth shattering at that hearing. And the one thing I've already beat up on is well known and for years, and so I think that setting thresholds and targets that are required for meaningful use that make practical sense and are reasonable are important because this is one area where I sure hope, in 2015, we can look back and say that 80% of scripts in the U.S. are going this way if we can get real benefit from it, and do it in a way that helps the clinicians and the hospitals and the pharmacies all to actually have a better system and patients to have a safer system, whatever it costs, but that it's a safer system and better for all.

Jason Brown – Epic – e-Prescribing Lead
This is Jason from Epic. One of the questions that didn't come up, and I assume it would be included in the concept, the spirit of the rule is, there's a lot of talk about the transmission of data using the NCPDP standard. In the cases though where an organization owns their own ambulatory pharmacies and prescribes out of that, if they have an integrated system that doesn't require the interfacing of data at all, does that count towards? I would hope that that would count towards both numerator and denominator for the 75%. And I think that'll apply to lab systems as well. I don't know if there's a percentage on lab systems, but that was one of the questions that I thought of afterwards, and I was wondering if the group had any thoughts on that and whether that is in fact in the spirit of the rule and should count towards both.

Deven McGraw - Center for Democracy & Technology – Director
I'm not sure I have the answer to your question, but I just want to pause for a moment and ask whomever is on the phone and making another call to please put us on mute.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I think that was Mike Klag, so I got distracted. Could you summarize that point again?

Jason Brown – Epic – e-Prescribing Lead
Yes. I guess the point is, there are large organizations that own their own ambulatory pharmacies and do a majority of their prescribing through those organizations or through their own pharmacies for cost-savings, and there will be organizations that have an integrated ambulatory EMR along with the ambulatory pharmacy system, and there won't be the need to transmit that data via NCPDP or any method for that matter. It'll be part of an integrated database. My hope would be that although the rule focuses on the transmission of this data through NCPDP, that those situations where there is no transmission of data necessary would count towards both the numerator and denominator for calculating the 75%.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
But there is a transmission. And I think you correctly pointed out. If we create an exception for that, then we are exacerbating the problem with the labs. You obviously are going from an EHR to a pharmacy system. It happens to be your own, but wouldn't relaxing the standards compliance criteria cause us to not be spreading the use of standards throughout the community?

Jason Brown – Epic – e-Prescribing Lead

I'm actually referring to a case where there is literally no transmission of data. The pharmacy front end is displaying the same items that the ambulatory EMR populated. They both have access to the same database, and it's not….

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I see what you're saying. It's an integrated system, and you're saying that the denominator does not capture things that are not "transmitted".

Jason Brown – Epic – e-Prescribing Lead
And I don't know if it does or not, but I would hope that it would, and encourage in those cases where an integrated system is possible that I would include that because that'll be a large percentage of the prescribing that goes on in those organizations. And so I don't know if that needs to be addressed. Reading through the IFR, there are some comments that would suggest that maybe it's not – trying to parse it, it sounds like maybe it's not, but it clearly says that NCPDP 8.1 or 10.6 is required, and that would be the concern is that, in an integrated system, it would be nice. Yes. I mean, obviously you don't want to then force an integrated system to send messages to itself.

Deven McGraw - Center for Democracy & Technology – Director
Yes. This is Deven, Jason. I'm trying to think this through, and I'm looking at sort of what is in the meaningful use rule, and you have to hit – if you're an eligible professional, you have to generate and transmit at least 75% of permissible prescriptions, so not the ones that the DEA won't let you use. Using certified EHR technology, and it's the technology that has to have the ability to transmit using the code set. I mean, I'm sort of wondering whether there's a requirement. You have to use your EHR that has to be certified with the standard, but do you actually have to use the standard in transmitting the script is not totally clear.

Jason Brown – Epic – e-Prescribing Lead
Right.

Deven McGraw - Center for Democracy & Technology – Director
And it didn't get raised in our hearing, so on the one hand you could say, well, you know, that's something that they should comment on. On the other hand, when we put these hearings together, I think we acknowledged that we tried to get the full scope of comments on the table, but we may not have had the right person to have raised that one.

Jason Brown – Epic – e-Prescribing Lead
From Epic's perspective, we'll be including it in our comment back, our general public comment as well, and so that may be the most appropriate means of delivering this comment.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Yes. It sounds to me like it is, but I think it's a very good point that Jason just points out the complexity of what we're trying to do here.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Philosophically, it's another potential loophole.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Right.

Deven McGraw - Center for Democracy & Technology – Director

Yes. One could argue that if the meaningful use rule doesn't say you've got to use the standard for 75% of those prescriptions, then you don't.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
That's right.

Deven McGraw - Center for Democracy & Technology – Director
I mean, if that's what's in your system, and you have to be sending them through your system, it almost seems like you'd have to bend over backwards not to use it.

Jason Brown – Epic – e-Prescribing Lead
Right. I think the other thing that a lot of this discussion is around eligible prescriptions. One of the things that we encounter regularly, so far, most people say eligible prescriptions include things that are not controlled drugs. One of the problems – there are other problems that lead to things not being able to e-prescribe, including things that are too long for the NCPDP standard and other things. I don't know if there needs to be additional effort put into refining that list of what it means by eligible, or if that'll be up to each organization making their decisions as far as what they believe their eligible.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Does anyone else have a solution – this is Steve again – to the denominator problem? Just how are we going to reliably track all those paper ones that go out and what truly is or is not eligible?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
I would assume the denominator are claims based, so to the extent all – and Medicare, of course, has Part D, so all of the pharmacy claims, one would expect 75% of the non-controlled substances would be transmitted using a certified EHR.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Does anyone from HHS, ONC know, does Medicare have the ability to link up pharmacy claims like for Part D to an NPI number to know the total universe of physician prescriptions paid for by Medicare, written by a single provider?

Deven McGraw - Center for Democracy & Technology – Director
Jessica, are you still on? Do you know?

Gayle Harrell – Florida – Former State Legislator
This is Gayle. I asked that question at the hearing. Was Medicare going to be able to handle the kind of evaluation that was going to be necessary, and we got kind of a, well, you know, that's why we're doing attestation the first year.

Deven McGraw - Center for Democracy & Technology – Director
Right.

Gayle Harrell – Florida – Former State Legislator
And, well, we'll be up and running by the second year. Well, that's a question that needs to be defined and really answered.

Deven McGraw - Center for Democracy & Technology – Director
So it is through attestation, so you have to come up with your own denominator and numerator.

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Well, with audits, and so I guess what's being asked is, is there a quantitative way to audit this. Gosh, I assume so.

Jonathan Ishee - Department of HHS - Policy Analyst
This is Jonathan Ishee. I will circle back around with CMS and get you an answer.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Thank you. Yes. If there's a technologic way rather than a manual way to do this, that would be in the spirit of HIT adoption, I would think.

Deven McGraw - Center for Democracy & Technology – Director
Yes, it would.

Gayle Harrell – Florida – Former State Legislator
Yes. I don't think physicians want to count up their prescriptions.

Deven McGraw - Center for Democracy & Technology – Director
Yes. Okay. Anything else? We may actually be able to end early. Micky?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
No, I don't think so.

Deven McGraw - Center for Democracy & Technology – Director
Before we bring the public in, we will – Micky and I will work on messaging these recommendations that we discussed today and getting them back out to you to make sure that we've appropriately captured them.

Kelly Cronin – ONC HIT DHHS – Director
Actually, Deven, I have a question to pose to the group. Maybe you covered this already, but has anyone talked about the interaction between the NHIN recommendations to the policy committee and how that sort of tracks with the IE recommendations around meaningful use and sort of where things are starting? This is really more of a global question, where things are starting in stage one versus where they might go in stage two and stage three, and is it strong enough to sort of achieve some of the goals that this workgroup has talked about?

Deven McGraw - Center for Democracy & Technology – Director
Kelly, that's a really good question. I think it's worth some further discussion because it appears that in fact the NHIN workgroup, once it's sort of put forth its kind of basic framework of – you know, the new conception of the NHIN is not a thing, but as a sort of collection of policies and standards and services. It now appears that they're sort of diving into some of the issues that we raised at the very beginning as being necessary for data exchange that would require sort of further deliberation like identification and authorization, building a trust framework, all of that stuff that we said in the very beginning had to get resolved.

I think it's a little unclear, to be quite honest, now that there is an NHIN workgroup, and they're thinking about how to dive into these issues, and we still exist. Who is supposed to do what, a basic question? And there are also some, by the way, overlaps to what would otherwise fall into the privacy and security workgroup's domain.

Kelly Cronin – ONC HIT DHHS – Director
Yes.

Deven McGraw - Center for Democracy & Technology – Director
…answer to the question.

Kelly Cronin – ONC HIT DHHS – Director
Yes. It's tough. I mean, particularly figuring out sort of how we're going to organize everything going forward. I guess I was most concerned about the feedback on the meaningful use in the interim final rule on standards. Globally speaking, where this workgroup has been talking about some of the things that are really important to drive in the short-term, does the stage one meaningful use requirements go far enough? And do we think that it's sort of respecting what the overall sort of … and intent of the recommendations presented over the summer represented? Or is it just really being sensitive to what's feasible as opposed to what's desirable from a policy perspective?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Kelly, are you asking where is that question going to get addressed?

Kelly Cronin – ONC HIT DHHS – Director
I think the opportunity to address it is on February 17th.

Deven McGraw - Center for Democracy & Technology – Director
Kelly, this is Deven. It goes back to the question that we raised at the very beginning about how much actual exchange of information can you expect in stage one when you're still in the process of trying to connect people.

Kelly Cronin – ONC HIT DHHS – Director
Right.

Deven McGraw - Center for Democracy & Technology – Director
The stage one criteria across the board favor more of getting the data in, getting the providers more comfortable with manipulating the data and using it with the expectation that, in stage two, there would be more exchange for care coordination and, of course, the two areas where in fact there are some more robust requirements for exchange of data across enterprises is lab and e-prescribing where you at least have to have the capacity to pull data in from somewhere else or send data out to somewhere else in the case of e-prescribing. In some respects, one could say, well, that's what we were all told is where we're supposed to be headed for stage two. More robust exchange and building the policies and standards that need to be in place to do that, whether it's through NHIN discussions or otherwise. Does that make sense?

Kelly Cronin – ONC HIT DHHS – Director
Yes. No, I think that's sort of a logical perspective from where we sit. I think it'd be interesting to hear from others in the group about, from a provider perspective, is there really an incentive to go to stage two when it's not clearly spelled out in the reg text or in a great deal of detail. So does the trajectory matter if it's not where the money actually is going in 2011?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
This is Steve Stack. I guess … how to say this. I think that for the typical physician provider, that the level at which we discuss these things is going to be way beyond them. And I think that here's how a lot of them are going to look at it. I understand that this is where things are going. I understand that if I'm

going to continue practicing medicine for the next 10 or 20 years, I'm going to have to do this. And so then they're going to go out, and they're going to try to comply with what they can and hope that they get some of these dollars on the backend to help underwrite that.

I don't think they are going to think through all the trajectory of where this is going. I think they're going to rely on people like us on these workgroups and the government and the vendors and the industry to design a system for them to use that if they, in good faith, go out and purchase the products and redesign their workflows will get us to the point that we lead them. I don't think they're going to think through all this about where the final trajectory is.

Kelly Cronin – ONC HIT DHHS – Director
Right. Given that they may not have the inclination or the expertise or the staff to become sort of highly sophisticated purchasers with regard to the various options that might exist to do different kinds of connectivity, and there's going to be an enormous amount of noise in the marketplace on who can do what. I'm just wondering, how does this all come together, and is it something that you all want to comment on?

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
One more thing on that. This is Steve. I think how it should come together is I agree with what Deven was saying. I think that, in 2011, the overwhelming emphasis really needs to be on getting – it's not putting a computer in every doctor's office and stuff. It's about getting people in front of software and computers that begins to collect data in a structured format, and then incrementally evolving in the following years how the data that is now being captured in a structured format can then be interchanged between different people working on behalf of a patient. I would favor that wherever possible 2011 has the emphasis on collecting data in a structured format rather than exchanging a lot of it.

Kelly Cronin – ONC HIT DHHS – Director
Right.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
Except for electronic prescribing because I think that's really pretty much, like I said, on the precipice for being ready to go.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I think it's certainly true that while it isn't sort of at the forefront of what's required for 2011, if we don't get started now on a whole bunch of things, it'll be very difficult for physicians to achieve it in 2013.

Kelly Cronin – ONC HIT DHHS – Director
I guess maybe then the question is, are we going far enough to at least do some of the foundational work for 2013, or is the collective requirements going to point people in the direction of just a lot of different proprietary connections that won't necessarily be the most efficient way to go?

Paul Tang - Palo Alto Medical Foundation - Internist, VP & CMIO
Do you have suggestions for how we could point in a better direction in 2011?

Kelly Cronin – ONC HIT DHHS – Director
Well, it's not really my place to do that, for you guys to go, but we're hearing a lot of anecdotal feedback that it's going to be – people could rely on either misinformation or whatever they've already invested in without necessarily thinking about how they're going to bridge to something that's perhaps going to be more of a scalable option and a cost efficient option across geographies down the road.

Deven McGraw - Center for Democracy & Technology – Director
Yes. This is Deven. I think that's right, Kelly. I think it then becomes incumbent on us to move as swiftly as possible to thinking about what's going to be – to specify, not just thinking about, but specifying our set of expectations for stage two because the systems that providers and hospitals are purchasing to meet stage one ought to be able to flip to the next stage without the need for substantial retrofit, or we have really got a big problem on our hands. And so, while we recognize that this has got to be incremental, that just means that we don't have much time to sort of say, whew. Breath. Done that.

I mean, we ideally ought to be identifying candidates for stage two in a more aggressive way, to the extent that we can. Does that make sense? We sort of got the message and understand the need to do this on a step-by-step basis. On the other hand, I don't think there's anybody on the call who doesn't foresee that you've sort of got to immediately start putting out what the expectations are for the later stages so that people can be prepared for them, and what are they.

Kelly Cronin – ONC HIT DHHS – Director
Yes. I'm also wondering whether the workgroup would benefit just from good market intelligence and maybe sort of an economist perspective on transaction costs on the way things that – on different ways this could play out because I don't think, in the end, it's in anyone's interest to sort of promote a set of requirements for meaningful use that's going to end up increasing or making a larger than necessary number of connection points and having, perhaps, a more sort of market dominated way of expanding these services, which is not a bad thing because it could be really rapid and maybe work its way through over time. But if it's going to end up driving up transaction costs for providers, then it's not – and it could eventually be passed down to the consumer. Then you're not really maximizing consumer welfare, and you're not really thinking about sort of the best way to organize a new market in this area.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Kelly, are you thinking of these as being things that we would formulate as recommendations for the IFR and the NPRM, or is it recommendations perhaps on the 2013 program?

Kelly Cronin – ONC HIT DHHS – Director
Yes. I'm just thinking whatever the thinking of the group is that should be communicated on the 17th, and you guys had a great conversation about that today. But to me, there seems that the way that this is, that sort of the overall approach raises some overall market issues, and sort of is the strategy going to play out, and is it going to sort of drive the level of interoperability and exchange that is going to end up being a really competitive marketplace where consumers are going to benefit, and providers are going to have cost effective services, and they're not going to have a million different – you know, there's not going to be an inefficient amount of connection points in a highly fragmented system. I guess I'm just wondering if anyone has thought about this at a more global level that would be worthy of commenting on.

Deven McGraw - Center for Democracy & Technology – Director
I suspect that many of us individually have thought about it, and thee certainly have been strains of conversation that we, as a workgroup, have had in the past, but that is not been what we've been focused on lately, and I guess I'm suggesting that I don't think we're prepared to offer anything on the 17th beyond an acknowledgement of the need to rapidly move to the next step. Folks can correct me if I'm wrong, but I think one of the strengths of what we've been able to do as a workgroup is that we have presented recommendations that we've spent considerable time developing and that represent a consensus of our diverse membership. And so, I would be hesitant to start raising some new things that we hadn't really had time to digest in a lot of detail … more time to do it.

Kelly Cronin – ONC HIT DHHS – Director
Yes. No, that makes a lot of sense.

Steven Stack – St. Joseph Hospital East – Chair, ER Dept
And I think that that point you're raising, I guess I'd look to what we're going to see in all the comments, the public comments that come in between now and March 15th because I think that a lot of the people who are going to be impacted by this will comment specifically on things like that.

Deven McGraw - Center for Democracy & Technology – Director
And I guess I would also put in a plug for some sort of more clarity of sort of what the expectations are for this workgroup vis-à-vis NHIN and any of the others going forward. Now that the sort of basic groundwork has been laid and adopted by the policy committee, there's now even more sort of unclear boundaries about who's responsible for what. It would be helpful to get some clarification on because we thought we were going on hiatus.

Kelly Cronin – ONC HIT DHHS – Director
Right.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Is that something that we just want to raise on the 17th, Deven, just as a question, and then sort of seeking advice from the policy committee as to what are the respective roles of these different working groups, and clarifying that a little bit more?

Deven McGraw - Center for Democracy & Technology – Director
I think it would be helpful, although I don't want to waste a minute of whatever time we get in our presentation beyond the sort of important points that we need to make on the NPRM and the certification IFR. I think there are usually other opportunities for those of us who sit on the policy committee to actually raise that. And if we actually manage to get through what we're doing in prompt time, then yes, I don't see why not.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
The cochair is on the call, I think, still, so presumably the message is getting there anyway.

Deven McGraw - Center for Democracy & Technology – Director
Anything else before we invite the public in for some comments?

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
I think we're all set.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya, could you ask the public if anybody wishes to make a comment?

Operator
Yes. (Instructions given.)

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. A reminder to the public to please identify your name, organization, and comments are restricted to three minutes. Thank you.

Operator
We do not have anyone from the public calling in.

Judy Sparrow – Office of the National Coordinator – Executive Director
Great. Thank you. Deven, back to you, Deven and Micky.

Deven McGraw - Center for Democracy & Technology – Director
Okay.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Darn. We're just talking to ourselves again.

Deven McGraw - Center for Democracy & Technology – Director
I think we can give people back 45 minutes of their time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you so much.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Great. Thank you, everyone, so much. This has been a great conversation.

M
Thank you.

M
Thank you, Micky and Deven.

M
Well done. Bye-bye.

Micky Tripathi - Massachusetts eHealth Collaborative - President & CEO
Thank you, everybody. Bye-bye.